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Settlement-Integrated Refugee Mental Health

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In this community-based naturalistic study, we investigated a "settlement-integrated" model of mental health care for refugees. Mental health care was coordinated through a settlement agency and a team of multilingual, culturally responsive settlement workers and counsellors, who provided supported referrals and counselling to address symptoms of anxiety, depression, and posttraumatic stress disorder (PTSD), as well as social and cultural adjustment issues. A mixed-methods design was applied with the aim of assessing the reduction of symptoms of depression (Patient Health Questionnaire Depression Scale–9), anxiety (Generalized Anxiety Disorder Scale–7), and PTSD (Harvard Trauma Questionnaire–16); evaluating client satisfaction using a seven-item questionnaire; and understanding the clients' experiences of counselling using semistructured qualitative interviews. Over the course of the intervention, refugee participants (N = 74, response rate = 86%) in the settlement-integrated mental health programme demonstrated significant reductions in anxiety, $t(73) = 12.89$, $p < .001$, $d = 1.9$; depression, $t(73) = 10.77$, $p < .001$, $d = 1.3$; PTSD, $t(73) = 10.77$, $p < .001$, $d = 1.3$. Qualitative interviews with refugee participants offered (a) insights into the burden of untreated mental health problems, (b) their perceptions of mental illness and treatment, (c) their experiences of settlement-integrated mental health services and counselling in first language, (d) their observations of their own progress, and (e) their appraisals of the counselling experience. These mixed-methods results suggest that specialized, culturally responsive mental health services offered within a settlement setting reduces barriers to mental health services by being responsive to the needs and preferences of refugees and is effective in the reduction of symptoms of anxiety, depression, and PTSD.

Public Significance Statement
Refugees face significant barriers to accessing the public mental health system in Canada. This study investigated the effectiveness of a model of mental health care for refugees in which counselling services were coordinated through a settlement agency and delivered by a multilingual, culturally responsive, multidisciplinary team. The results suggest that the interventions had an important role in reducing symptoms of anxiety, depression, and PTSD, and that participants were highly satisfied with their counselling experience.

Keywords: refugee mental health, community-based research, mixed-methods

Refugees who have recently arrived in Canada have unique mental health risks and service needs, and they also face particular barriers to accessing adequate and acceptable mental health care. Despite their cultural and sociopolitical diversity, refugees are often exposed to traumatic premigration experiences which can significantly increase the risk for mental health problems (Nickerson et al., 2014; Rousseau & Drapeau, 2004; Silove et al., 1998; Tay et al., 2015). Furthermore, once they arrive in Canada, refugees can experience discrimination and racism, precarious material conditions, inadequate social connection, the loss of important life projects and social roles, and the loss of meaningful structure and activity in daily life; and these can also jeopardize mental health and well-being (Beiser, 2009; Beiser & Hou, 2017; McKenzie, 2019).

While most refugees adapt well once they have settled in a safer place, a small minority do experience major mental health challenges which, when left untreated, can persist as chronic distress and dysfunction (Rousseau et al., 2011). Research suggests that among adult refugees living in high-income countries, approximately one in 10 has posttraumatic stress disorder (PTSD), one in 20 has major depression, and one in 25 has a generalized anxiety disorder, with these disorders overlapping in many people (Fazel et al., 2005). PTSD is of particular concern, as its prevalence in refugee populations is higher than the general population in Canada, it is a potentially disabling condition, and it is a risk factor for substance abuse and suicide (American Psychiatric Association, 2013; Rousseau et al., 2011; Van Ameringen et al., 2008). These mental health disorders can contribute to poor settlement outcomes when they impact refugees' ability to learn new languages and adapt to changes in social roles and employment expectations (Berry & Hou, 2016; Rousseau et al., 2011).

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Refugees face significant barriers to accessing the public mental health system in Canada (Agic et al., 2016). While the prevalence of mental health problems is higher in refugee populations than in the general population, refugees in Canada use mental health services at a much lower rate than average (Agic et al., 2016; Mental Health Commission of Canada, 2016; Rousseau et al., 2011). One of the most important barriers to service is language (Langlois et al., 2016; Priebe et al., 2016). There is little to no publicly available mental health care in first language, for refugees who do not speak English or French, that would be comparable to the quality of care that is available to majority-language speakers (Agic et al., 2016; McKenzie, 2019). Beyond language, however, there are concerns about the cultural appropriateness of psychological assessment and treatment techniques, the cultural responsiveness of service providers, and the stigma of mental health which may impede access, utilization, and effectiveness of services (Agic et al., 2016; McKenzie, 2019). Furthermore, the complex mental health needs of survivors of war and torture are new and unfamiliar to most care providers and health care organizations (Im et al., 2021; Wylie et al., 2018). Finally, research has shown that non-European newcomers to Canada may perceive an overreliance on pharmaceutical treatment and a dismissive attitude on the part of mental health service providers, and they may also prefer more culturally familiar or traditional forms of care for emotional or mental distress (Whitley et al., 2006).

This settlement-integrated refugee mental health approach was designed to create a bridge between mental health services and refugee resettlement programs, which typically operate independently (Im et al., 2021). "Settlement services" are funded through the Canadian government and are often delivered by community-based nongovernmental organizations. The aim of settlement services is to provide immigrants and refugees with information, language instruction, and skills development support to enter the employment market and other practical assistance to facilitate their integration into Canadian society (Government of Canada, n.d.).

Formal mental health care does not currently fall within the mandate of settlement services; however, the federal government does provide insurance to cover mental health treatment for government-assisted refugees (GARs) during their first year in Canada under the Interim Federal Health Program (IFHP). While IFHP funds private individual psychotherapy services provided by regulated mental health professionals, this service delivery model does not address many of the barriers listed above. IFHP establishes a list of providers who will accept reimbursement for services. It does not provide any information about navigating the mental health system in Canada nor specifically locate mental health services within community-based settings that are familiar to refugee populations. This funding model also does not include mechanisms to identify refugees at risk, facilitate effective referrals to care providers, address the stigma of mental health that may create barriers to access, ensure mental health care is culturally appropriate and offered directly in refugees' first language, or ensure that clinicians are familiar with the complex mental health needs of this diverse population. Additionally, as many refugees may not be ready to engage in treatment within their first year of arrival, when they are preoccupied with critical tasks related to settlement and adaptation, this federal funding does not extend long enough to address the longer term effects of persecution and trauma (Nickerson et al., 2011; Tull et al., 2004).

There are many compelling reasons to coordinate mental health services using a settlement-integrated approach for refugee populations and to produce research on the outcomes of this approach. First, settlement agencies are usually the point of first contact when refugees arrive in Canada and the workers at these agencies frequently develop trusting and supportive professional relationships with refugee newcomers that extend into communities (Beiser, 2009; Berry & Hou, 2016). Bilingual settlement workers offer services that address social determinants of mental health, such as assisting refugee clients to secure basic needs, providing information and orientation, language instruction, and psychosocial support (Berry & Hou, 2016). Furthermore, because settlement workers have regular contact with individual refugees and often provide informal emotional support, they are well-placed to identify refugees who may need specialized mental health support (Beiser & Hou, 2017). They can also provide accurate information about mental health treatment, they can allay fears and address stigma, and they can facilitate sensitive and effective referrals (Wylie et al., 2018). Mental health and settlement services that are co-located and integrated can provide a wraparound approach that addresses complex needs.

Finally, despite the availability of a small number of meta-analytic studies examining the prevalence of mental health disorders in refugee populations (Fazel et al., 2005; Porter & Haslam, 2005) and an emerging body of efficacy evidence (Campbell, 2007; McFarlane & Kaplan, 2012; Nickerson et al., 2011; Patel et al., 2014; Slobodin & de Jong, 2015), there is little evidence of the effectiveness of settlement-integrated interventions which are specifically aimed at reducing barriers to care (Im et al., 2021; Lindencrona & Ekblad, 2006; van Wyk & Schweitzer, 2014). There is a complete dearth of qualitative research offering refugee's insights on their experiences of counselling in first language in postsettlement settings, and this is important data when considering the cultural relevance and acceptability of mental health care.

Research Design

Given the barriers for refugees to accessing mainstream mental health care, the proposed strengths of a settlement-integrated model, the limited findings on the effectiveness of settlement-integrated care, and the dearth of qualitative research on refugee participants' experience of settlement-integrated care, we designed a community-based, naturalistic study to investigate the effectiveness of a settlement-integrated approach to refugee mental health. This study used a mixed-methods approach aimed to (a) provide ecologically valid findings on counselling outcomes for a particularly vulnerable and underserved population, (b) inform clinical practice and programme development, and (c) provide community-level data needed to inform public mental health and settlement policy decisions.

Mixed-methods approaches in counselling psychology research are employed to obtain generalizable data while also providing deeper insight into the phenomena of interest (Bailey-Rodriguez, 2021; Hanson et al., 2005). Symptom measures commonly used in clinical settings were used to determine inclusion criteria and to provide important data about changes in mental health status over time and a questionnaire was developed to measure clients' satisfaction with counselling. We integrated an interpretive description approach, which seeks to "generate better understandings of complex experiential clinical phenomena within nursing and other

professional disciplines concerned with applied health knowledge or questions from the field" (Thorne, 2008, p. 27). The methods employed by this study emphasize both objective measures of change as well as the subjective experience of participants, as both aspects of knowledge are important in evaluating not only the effectiveness of a novel intervention but how "accessible, acceptable, and appropriate" the intervention is, as perceived by participants (Clark & George, 1993).

In this intervention, mental health care was coordinated through a settlement agency and delivered by a multilingual, culturally responsive, multidisciplinary team. Our approach included supported referrals and multilingual, trauma-informed, and culturally responsive assessment and counselling to address adjustment issues as well as symptoms of anxiety, depression, and PTSD. The intervention used in this pilot project was modelled to address gaps in the mental health coverage that is provided to GARs during their first year in Canada under the IFHP. This programme aimed to provide a comparable number of sessions as are funded by IFHP, while addressing the gaps and barriers described above by integrating formal mental health services into the settlement service context and expanding the eligibility criteria to within 5 years (instead of 1 year) of arrival in Canada.

The design of the settlement-integrated intervention was underpinned by principles of trauma-informed and culturally responsive care, as well as a respect for fundamental human rights. Trauma-informed care is based on the understanding that the impacts of trauma are often widespread and multigenerational, and it aims to integrate knowledge of trauma and prevention of retraumatization into all aspects of mental health services (Im et al., 2021). Culturally responsive care integrates language needs and cultural preferences into all aspects of care and involves providers efforts to learn about their clients' cultures, the expressions and meaning of distress, and to establish acceptable ways of communicating with each client (Im et al., 2021). Furthermore, this settlement-integrated model was designed to follow the human rights-based guidelines that are promoted by the United Nations Office of the High Commissioner for Human Rights and the World Health Organization. These guidelines promote health care that is community-based, not excessively medicalized, addresses societal determinants and promotes autonomy, resilience, social connection, and healthy relationships (Office of the High Commissioner of Human Rights [OCHR], 2019).

Participants

As shown in Table 1, eighty-seven potential participants were referred by settlement workers for initial screening. Three were found not to meet inclusion criteria for this programme after attending the preevaluation session. Four declined counselling after completing the intake. Six participants dropped out of treatment or did not complete posttest screening. Eighty participants were screened in and began their course of treatment, and seventy-four participants successfully completed (i.e., after 10 sessions or after fulfilling treatment objectives in agreement between the therapist and client) and participated in the postevaluation; thus, the response rate was 86%.

Table 2 presents the demographic and baseline clinical characteristics of the 74 clients who completed counselling sessions. Most clients (55, 74%) were between 31 and 50 years of age. Forty-four (59%) identified as women, 26 (35%) identified as men, and four (5%) identified as transgender. Using baseline Patient Health Questionnaire Depression Scale–9 (PHQ-9) score bands to assess severity of depression, there were 22 clients (30%) with moderate–severe depressive symptoms and 31 clients (42%) with severe depressive symptoms. For the GAD-7 scores at baseline, 13 clients (18%) were classified with moderate anxiety symptoms and 58 clients (78%) with severe anxiety symptoms. Using the Harvard Trauma Questionnaire (HTQ) cutoff score at baseline, 45 (61%) clients were symptomatic for PTSD on intake.

Table 1
Response Rate

Category	*N*
Total referrals by settlement workers	87
Did not meet inclusion criteria	3
Declined counselling sessions	4
Dropped out/did not complete	6
Completed intervention	74
Response rate	86%

Table 2
Baseline Measures of Those Who Completed the Programme

Demographic and baseline	*N* = 74	/100
Age group		
20–30	9	12%
31–40	32	43%
41–50	23	31%
51–60	8	11%
61–70	2	3%
Country of origin		
Iran	39	53%
Syria	16	22%
Afghanistan	8	11%
Iraq	6	8%
Other	5	6%
Language		
Farsi	38	51%
Arabic	25	34%
Dari	9	12%
Spanish	2	3%
Gender		
Women	44	59%
Men	26	35%
Trans	4	5%
GAD-7 baseline		
No impairment (0–5)	0	0
Mild impairment (5–9)	3	4%
Moderate impairment (10–14)	13	18%
Severe impairment (15–21)	58	78%
PHQ-9 baseline		
No impairment (0–5)	2	3%
Mild impairment (5–9)	4	5%
Moderate impairment (10–14)	15	20%
Moderate–severe impairment (15–19)	22	30%
Severe impairment (20–27)	31	42%
HTQ baseline		
Positive for PTSD (3.25 or greater)	45	61%
Negative for PTSD (less than 3.25)	29	39%

Note. GAD-7 = Generalized Anxiety Disorder Scale–7; PHQ-9 = Patient Health Questionnaire–9; HTQ = Harvard Trauma Questionnaire; PTSD = posttraumatic stress disorder.

Measures

Depression was screened with the nine-item PHQ-9 (Kroenke et al., 2001), which ranges from 0 to 27 with a recommended cutoff of 10 or above for distinguishing between clinical and nonclinical populations. Anxiety was screened with the seven-item Generalized Anxiety Disorder Scale, which ranges from 0 to 21 with a recommended cutoff of 10 or above for distinguishing between clinical and nonclinical populations (GAD-7; Spitzer et al., 2006). Symptoms of PTSD were screened with the 16-item symptom questionnaire of the HTQ, which was designed for use with refugee populations, with 2.5 suggested as the clinical cutoff score indicating that a respondent has a high likelihood of PTSD (Berthold et al., 2019; Mollica et al., 1992).

All clients who completed the postevaluation were asked to complete a seven-item satisfaction survey. Clients responded to the following questions:

1. I felt understood by the therapist.
2. In my sessions, we discussed things that were important to me.
3. I can cope with my problems better because of counselling.
4. The number of sessions was enough for me.
5. I had enough information about what to expect from counselling.
6. I was able to access my appointments easily.
7. Overall, counselling was helpful for me.

For the postevaluation assessment, a seven-item Client Satisfaction Questionnaire and a semistructured qualitative interview were added to this protocol. Screening protocols were created in English, Farsi, Arabic, and Spanish using translated versions of the above measures. Published translations in Arabic and Spanish were available for the HTQ, PHQ-9, and GAD-7. Farsi translations were produced for these measures, using principles of multicultural assessment including forward and back-translation (Mollica et al., 2004; Suzuki & Ponterotto, 2007).

Qualitative Data Collection and Analysis

Interpretive description aims to generate a "conceptual/thematic" descriptive product, in which patterns and meaning in the data are identified through analytic and interpretive processes (Thorne, 2008). Interviews occurred concurrently with the two-stage quantitative data collection process and were conducted using a semistructured, open-ended questioning format to explore and understand participants' perspectives on their mental health and their experiences of counselling. Seventy-eight participants completed pre- and post-intervention interviews. These included 74 participants who were screened in and successfully completed the intervention. As well, of the six people who dropped out, all were invited and four chose to participate in a postintervention interview. The qualitative data were analyzed for categories by the lead psychologist, using an inductive and iterative content analysis process, and generating thematic descriptions grounded in verbatim material with software support from MAXQDA (Bailey-Rodriguez, 2021; Hanson et al., 2005; Rivas, 2012; Thorne, 2008).

Procedure

The study was conducted at Immigrant Services of British Columbia (ISSofBC), a large non-profit-serving immigrant and refugee newcomers in Vancouver, Canada. Inclusion criteria were that prospective participants were GARs who had arrived in Canada within 5 years, were engaged in settlement programmes at ISSofBC, and were experiencing moderate-to-severe symptoms of anxiety, depression, and/or PTSD, without evidence of psychosis. The arrival within 5-year range was justified on the basis that, while GARs are only eligible for federally funded mental health services for the first year, research suggests that refugees are not always ready to access mental health treatment in their first year as essential survival tasks take priority—despite the presence of mental and emotional distress (Beiser & Hou, 2017). The programme was advertised to ISSofBC clients, and potential participants were either self-identified or were personally invited by settlement workers who were trained to make a lay observation about clients whose mental health seemed to be impeding their settlement process.

After clients were referred to the programme, they attended an initial preevaluation session with the lead researcher, who is a registered psychologist with specialized global mental health training and significant clinical experience with refugee populations. The psychologist conducted an assessment for symptoms of depression, anxiety, and PTSD with the assistance of trained professional interpreters, using translated instruments.

The psychologist screened clients for mental health inclusion/exclusion criteria (moderate-to-severe symptoms of anxiety, depression, and PTSD, without evidence of psychosis) and conducted a brief semistructured preintervention qualitative interview. Suicide risk was not a criterion for exclusion; however, if risk of self-harm was identified, a safety plan was put in place before the client was referred to counselling. At the end of the initial evaluation session, the psychologist provided each client psychoeducational information about their assessment results and a thorough orientation about what to expect from the counselling process, including how to provide feedback or change counsellors if the process was not satisfactory. They were offered an opportunity to discuss immediate concerns and ask questions of the psychologist conducting the evaluation. Evaluations were conducted with the aid of an interpreter using translated measures.

Specialized training sessions were provided to the settlement workers, counsellors, and interpreters, and ongoing consultation with the lead psychologist was available to all staff who were involved in the programme. For settlement workers, a full-day training included trauma-informed settlement service provision and culturally sensitive mental health referral (Im et al., 2021; Kirmayer et al., 2011). Registered clinical counsellors received a half-day training on refugee mental health, trauma-informed principles of care, and the local settlement context (Beiser, 2009; Beiser & Hou, 2016; Im et al., 2021; Kirmayer et al., 2011; McFarlane & Kaplan, 2012; Nickerson et al., 2011). Interpreters received a 1-hr training on ethics, confidentiality, managing dual relationships in community, gender affirming language, and trauma-informed self-care (Mental Health Commission of Canada, 2016; Miller et al., 2005).

Multilingual clinical counsellors provided up to 10 sessions of clinical services in the client's first language. A brief summary report of the assessment results was sent, with consent of the client, to the counsellor along with the referral. Given the heterogeneity of the client population, and to allow clinicians to respond to the unique presentations and cultural diversity of each client, counsellors used a humanistic, trauma-informed, culturally responsive counselling approach (Im et al., 2021; Rice & Greenberg, 1992). After clients had completed 10 sessions (or fewer, if they declined or did not require further service), they returned to the psychologist to complete the postevaluation screening, along with a Client Satisfaction Questionnaire and a qualitative interview about their perception of and satisfaction with counselling. Clients who dropped out of treatment did not complete the postevaluation screening but were invited to participate in the postevaluation interview so that they could share their appraisal of counselling, obtain additional referrals, and receive the honorarium. All participants were offered an honorarium of $75 at the postevaluation session to acknowledge their contribution to the research process; however, to avoid financial inducement, they were not informed that they would receive an honorarium until they completed their counselling sessions. Logistical support was provided to help clients access their scheduled appointments, including public transportation tickets for each session, telephone reminders prior to each appointment, flexible scheduling that included evenings, weekends, and remote virtual sessions, and childcare.

Ethical Considerations

This study was conducted in compliance with the *Ethical Principles of Psychologists and Code of Conduct* (College of Psychologists of British Columbia, 2014). An institutional research oversight committee at the host agency reviewed the research proposal, prior approval was granted, and the study was conducted in accordance with the approved research protocol. Information for participants was translated, explaining risks and benefits and that participation was voluntary and could be withdrawn at any time without negative consequences.

Limitations

To conclusively determine if a programme has had the intended impact, baseline and control group measurements must be designed into the evaluation strategy. However, given the vulnerability of this population and the absence of comparable alternative services, the institutional oversight committee determined that control group and wait-list designs were neither appropriate nor ethical. The absence of a control group, the lack of randomization, and the many sources of variability make it impossible to generalize the findings to the refugee population.

Results

Statistical Results

Dependent samples *t* tests were calculated to assess changes in scores on self-report measures from pre- to post-treatment. Cohen's *d* was calculated for each analysis as a measure of effect size. SPSS software was used to perform statistical analysis. The means and standard deviations are presented in Table 3. Over the course of treatment, participants in the settlement-integrated mental health programme demonstrated significant reductions in anxiety, $t(73) = 12.89$, $p < .001$, $d = 1.9$; depression, $t(73) = 10.77$, $p < .001$, $d = 1.3$; PTSD, $t(73) = 10.77$, $p < .001$, $d = 1.3$. This strongly suggests that the given treatment method significantly reduces GAD-anxiety, PHQ-depression, and HTQ-trauma scores. The effect sizes were all large; however, the effect sizes for anxiety and depression were substantially greater than the trauma effect size.

Table 3
Descriptive Data

	Baseline		Final		
$N = 74$	*M*	*SD*	*M*	*SD*	*d*
GAD-7	17.3	3.4	7.9	6.0	1.9
PHQ-9	17.3	5.5	8.8	7.6	1.3
HTQ-16	41.1	28.9	12.73	12.9	1.3

Note. GAD-7 = Generalized Anxiety Disorder Scale–7; PHQ-9 = Patient Health Questionnaire–9; HTQ-16 = Harvard Trauma Questionnaire–16.

Client Satisfaction

All clients who completed the postevaluation were asked to complete a seven-item satisfaction survey. Overall, as presented in Figure 1, 61 clients (83%) agreed or strongly agreed that counselling was *helpful* to them. Clients reported positive feelings towards their therapists, with 87% agreeing or strongly agreeing that they felt *understood* by their therapist and that they discussed things that were *important* to them. Seventy-two percent of clients agreed or strongly agreed that they could *cope* with problems better as a result of their counselling experience. Clients were fairly evenly split in their perception of whether the *number* of sessions was enough to help them meet their therapeutic goals. Forty-six percent agreed or strongly agreed that they had received enough sessions, while 41% disagreed or strongly disagreed. With bus tickets provided and counsellors offering flexible scheduling, 87% of clients agreed or strongly agreed that they were able to *access* their appointments easily.

Qualitative Findings

Semistructured interviews in the pre- and post-evaluation session and termination notes provided by clinical counsellors generated qualitative data on clinicians' objectives and outcomes observations, client's observations of their own progress and appraisal of the counselling experience, and the perceived value of a settlement-integrated model of mental health care for refugees. The information that emerged offers insight into (a) the burden of untreated mental health problems, (b) refugees' perceptions of mental illness and treatment, (c) the value of settlement-integrated mental health services and counselling in first language, (d) counselling objectives and outcomes, and (e) clients' observations of their own progress and appraisal of the counselling experience. These categories are elaborated in the following sections.

Burden of Untreated Mental Health Problems

Preevaluation screening results demonstrate that participants were moderately to severely symptomatic prior to accessing

Figure 1
Client Satisfaction

counselling services. Participants elaborated on the personal impact of untreated symptoms during the intake session, stating, for example, "I have no interest in daily activities," "the world is grey and empty for me now," and "I am having panic attacks in anticipation of having panic attacks." One participant described an experience common to sufferers of PTSD, "I avoid thoughts and feelings about the past. This helps me avoid suffering but it limits my experience of life." Participants also described the impact of symptoms on their relationship functioning and their capacity to learn and adapt.

Several clients were survivors of torture. During the preevaluation interview, one survivor reported, "I don't feel free. I feel like I am always under control, like [my former prison guards] are watching me." Another client explained, "I feel like I am no longer human. Through my experiences of harassment, discrimination, assault and torture I have lost my humanity." Another participant stated that, since being tortured "chronic pain limits me in so many ways. There are many things I can't do for myself and this increases my sense of isolation and depression."

Twenty-one (28%) participants endorsed suicidal ideation during the preevaluation screening. One such client described his situation as "hopeless" and "intolerable" and while he did not have a specific plan or the means available to end his life, he stated that he thought about suicide regularly and believed he would be better off dead.

While some participants spoke openly about the impact of mental health symptoms of their lives, others were stoic and reticent to disclose the extent of their suffering. Despite the severity of the symptoms they endorsed, many minimized the impact of their symptoms, stating, for example, that they did not wish to burden anyone.

Perceptions of Mental Illness and Mental Health Care

For the great majority of participants, this was their first experience discussing their concerns with a mental health professional. A few stated that they had accessed counselling before, either in their country of origin, in a transit country, or since arriving in Canada. Some refugee participants demonstrated positive attitudes about mental health services and expressed no reservations about counselling, but a slight majority expressed thoughts and feelings about counselling that revealed some stigmatizing beliefs. For example, some said they believed mental health treatment was for "weak" or "crazy" people and expressed fears that in experiencing mental and emotional distress and dysfunction they were abnormal, would be permanently disabled, or would be ostracized by people in their community.

Counselling in First Language

All clients were matched with a counsellor who spoke their first language. Many were immediately appreciative of this, such as the client who stated, "She spoke Arabic, so we could really feel each other. I know she understood not just my language but also my way." Another client believed that therapy was only possible in his original language, stating:

> Though I am fluent in English, I have to work at it and I'm always translating my thoughts and feelings. I need to be able to speak my first language, straight from my heart.

Clients also appreciated that counsellors had bicultural knowledge to help them adapt to a new life in Canada. As one client explained:

> My main task at this time in my life is to settle myself here in this place. There are a lot of things I need to get used to. The counsellor helped me understand the people here and why they do the things they do. This helped me feel more comfortable.

Many refugee participants disclosed that they did not initially feel comfortable about being referred to a counsellor who spoke their language and who was assumed to share a similar cultural or national background. Because refugees have fled persecution, many participants did not trust that a person from their country would provide safe, trustworthy, unbiased, confidential care. Several participants initially stated that they would rather meet with a therapist from outside the political, religious, and social context of their home culture. As one client explained, "I do not trust easily, and when [the settlement worker] told me that I would be meeting someone from my country I refused." One client observed that just because a counsellor and client share language and cultural background, it is does not follow that they share values or social history.

In discussing the referral options, clients generally accepted that it would be more comfortable for them to speak directly without an interpreter because they trusted a trained professional counsellor more than an interpreter to maintain confidentiality. They were also assured that if they did not feel safe or confident with the counsellor, they could change or stop at any time. One participant explained:

> When you first suggested to see someone from my own country, I was afraid. We had some very bad experiences, lots of persecution, and this is why we ran away from there. I cannot be sure that I will be safe with someone from my country. But when I met this counsellor, I was sure. Trust is more complicated with someone from home, but when it works, it is definitely much better.

In the postevaluation conversations, participants described "taking a risk" and finding out that they could trust the counsellor more deeply over time, and that they appreciated the ability to speak from the heart and to feel comfortable in a shared cultural understanding.

As with any counselling process, success depends not only on shared language and culture but also on skill and a perception of effectiveness and "fit." One client, who had requested to transfer to a different counsellor after a few sessions, explained:

> The counsellor I saw before was also speaking my language, so that is not the only thing that is important. There are obviously differences between counsellors. The first counsellor just listened and commiserated, and that was not very helpful.

Refugees Self-Reported Progress

Participants reported observations of their own progress, which included fewer symptoms, better coping skills, decreased distress, increased acceptance, increased self-knowledge, greater confidence, resolution of grief, more positive feelings about living in Canada, and increased optimism for the future. As one client stated:

> When I first came here, I was always thinking about the past. Now I am mostly focused on the present and even a little bit into the future. I have learned how to control my emotions and how to let go of those memories that troubled me.

Another client described a shift in her understanding of traumatic events, stating:

> Before, my feelings of anger were uncontrollable. Now, I have a better understanding of some of the things that happened to me, and I know that it wasn't right, and it should never have happened. I feel a sense of injustice, and this still makes me angry, but I feel like I am standing up for myself, not just passive, and it helps me feel better about myself because I know that it wasn't my fault.

A client concluded, "I know now that bad things can happen in life, but life will not destroy you."

Clients also reported on relational aspects of their mental health. They often stated that their mental wellness was tied to the well-being of important people in their lives. One participant said, "I think my symptoms will continue to improve if my son's situation gets better." They also reflected on how counselling helped them improve their relationships as couples and parents. One client described a multigenerational effect of counselling, stating, "I know that in healing myself and the past, I am giving an important gift to my children and their children and all the generations that come after."

Despite the significant positive changes from pre- to postevaluation, many clients reported experiencing persistent symptoms and having unresolved concerns after their counselling sessions ended. However, the majority of these clients noted that while symptoms remained, they were significantly reduced or had become more manageable. Some stated that they finished counselling with a better understanding and a greater sense of control of their trauma symptoms, such as this client who stated:

> Now I do not feel like I am swinging between re-experiencing and avoidance. I am intentionally avoiding thoughts and feelings and certain activities, because I do not feel it is the right time for those things. I feel like this is okay for now.

As was evident from the postevaluation screening, approximately 20% of clients remained symptomatic of PTSD after completing their counselling sessions. In the qualitative conversation, some participants shared insights about their new understanding of and ability to cope with ongoing symptoms—things they had learned about the human responses to trauma that helped them make sense of their experiences and feel less overwhelmed and less distressed. As one participant explained, "the bad memories still come to me every day, but now I am able to put them aside and focus on something else. I don't feel as distressed as I used to."

A few participants, however, reported persistent distress related to PTSD symptoms, such as extremely low interest in daily activities, emotional numbing, intrusive memories, and generalized anxiety. One participant stated, "When I have problems in my daily life, it brings back all the memories of what I have experienced. I never feel free." Most of these clients reported that they felt cared for and supported by their counsellors and experienced some benefit from counselling, even if their symptoms did not improve very much. Finally, some clients explained that the settlement-related problems they were facing in their daily life did not allow them the safety and security needed to really begin to resolve their symptoms. As one participant reported:

> Though the counsellor really helped me, I am still struggling with all the same problems. I am not secure in my housing. I do not have enough money to buy proper food, and I am losing weight.

In this case, it was evident that while the client appreciated the care and support of the counsellor and may have increased their capacity to cope, their practical problems were still serious and overwhelming.

These outcomes suggest the need for longer term highly specialized treatment for a small subset of the refugee population.

Appraisal of the Counselling Experience

As the satisfaction survey demonstrates, overall, clients were highly satisfied with the counselling experience. In the qualitative interview, most clients had overwhelmingly positive things to say about their counsellors. Participants commented on qualities that they appreciated in their counsellor, such as professionalism, being accepting and nonjudgemental, and demonstrating genuine care. Many counsellors used a strengths-based approach that clients noticed and appreciated. Several participants experienced counselling as a unique and transformative life experience. One stated:

> This was the first time I ever saw someone consistently week after week for 10 sessions. It was extraordinary to meet someone like that. I never had someone really listen to me, really see me for who I am and understand me. After years of living like a ghost, I cannot tell you how important that was.

Clients appreciated having an hour per week to focus exclusively on themselves and their own concerns, to have someone listen to them with undivided attention, to receive empathy and genuine care, to learn coping strategies, and to gain relief from painful emotions and distressing symptoms. Clients also appreciated having someone who could assist them with the wide range of presenting issues common in resettled refugee populations. As one client stated:

> The counsellor helped with many different issues. Though I had a specific phobia and she worked on that, she also helped with my relationship, parenting, and the overall experience of adjusting to this new country.

The Trans people (4) who participated in this project spoke to the need for counsellors to be knowledgeable of the forms of persecution based on gender identity that many refugees can experience, to provide gender affirming care and to be able to refer to and collaborate with appropriate medical and community services when needed. As one Trans participant explained:

> The counsellor really understood me and knew what I am going through. She gave me information about the process of gender reassignment, supported me through all the changes that are happening in my life, and helped me relate better to other people.

Trans clients, in particular, described ongoing experiences of discrimination and marginalization after arrival in Canada and highlighted the need for settlement, counselling, and medical care providers with specialized knowledge and advocacy skills.

While most clients declined to offer feedback on improvements, some made suggestions that they thought would improve the programme or counselling experience for others. The most common response was that 10 sessions felt insufficient. A few reported less-positive experiences with counsellors and counselling, but of these, all but two requested to change and had a more positive experience with a second counsellor.

Discussion

Our findings suggest that the settlement-integrated model is effective and can facilitate greater access to mental health services for refugee populations, which are at a higher risk for common mental health problems than the general population and are less likely to seek care. Recent literature describes the effectiveness of co-located and collaborative primary and mental health care for migrant populations in high-income countries (Lu et al., 2020). Like primary care facilities, settlement services agencies are an early point of contact for refugees, but they have the added benefit of employing workers with cultural knowledge, language skills, and an understanding of the complex challenges of migration—which are unfamiliar to most providers in health care organizations (Wylie et al., 2018).

Participants in our study described how the settlement-integrated approach allowed them to overcome barriers to mental health care that have been identified in the literature, including language barriers, cultural stigmatization of mental health conditions, and unfamiliarity with the health care system in the host country (Kirmayer et al., 2011; Lu et al., 2020; Shannon et al., 2015; Whitley et al., 2006), as well as the prohibitively high cost of private therapy services, transportation costs, and lack of childcare. A mental health service embedded within a trusted community organization appears to have increased referral success by addressing these barriers by providing free services, accessible psychological education and health systems navigation information, logistical and financial support, as well as counselling in first language.

Research findings related to mental health stigma in refugee populations tend to acknowledge that stigma exists and is a significant barrier. Shannon et al. (2015) identified seven categories that refugees offered as explanation for why it is difficult to discuss mental health, which are distinct from a traditional definition of stigma: (a) history of political repression, (b) fear of community judgement, (c) a belief that talking does not help, (d) lack of knowledge about mental health and mental health treatment, (e) posttraumatic avoidance symptoms, (f) shame, and (g) cultural values and beliefs. Participants in this project shared feelings about seeking mental health care that corresponded with each of these categories and which needed to be addressed before they could engage in counselling.

Refugees, as people who have experienced politically motivated trauma or oppression that frequently results in psychological distress, are often reluctant to discuss those experiences and resulting symptoms. Furthermore, while talking about traumatic or distressing experiences can be extremely uncomfortable and can trigger symptoms for anyone who has had severe traumatic experiences, refugees must often narrate traumatic history for immigration proceedings and frequently experience retraumatization when telling their stories in nontherapeutic contexts (Huminuik, 2017). As participants in this project demonstrated, clinical symptoms of psychological distress, the avoidance of symptoms, and the experience of retraumatization on exposure to traumatic material, rather than or in addition to stigma, likely contribute to a sense of wariness about trauma-focused disclosure as a therapeutic process (Shannon et al., 2015; Tull et al., 2004).

Mental health care for refugees is complex and requires a special set of skills, which include culturally appropriate clinical assessment and treatment, the ability to build trust and create a cross-cultural therapeutic alliance, knowledge of migration and settlement, and working with interpreters (Kirmayer et al., 2003). The interdisciplinary, community-based approach of this project drew collaboratively on the skills of a psychologist, counsellors, and settlement

workers, all with lengthy experience providing care for refugees. The multistage referral process included psychological education and social support intended to allow for fully informed consent and to address the particular types of stigma described above. Many participants reflected on the benefit of a step-by-step process of having a trusted settlement worker raise the possibility of counselling, receiving more information, and having a chance to ask questions of the assessing psychologist, and then meeting the counsellor and developing a sense of trust and a better understanding of the process of counselling, which slowly allayed their concerns and allowed them to develop a strong therapeutic alliance and participate fully in the counselling process. Clients also often reported that they needed help with the stressors of daily living, but that they did not want counsellors to focus on immediate concerns at the expense of understanding their trauma history and other important aspects of their personality and context. Counsellors frequently noted that they addressed settlement concerns concurrently and worked collaboratively with settlement workers. As evinced by the high completion rate, overall satisfaction with services, and qualitative appraisal of counselling services, a well-balanced collaborative approach, in which psychologists, counsellors, and settlement workers are in active partnership, appears to promote engagement, increase therapeutic alliance, and prevent premature dropout.

The growing body of research on the effectiveness of psychotherapy for refugees largely concludes that they have greater symptom severity, have less access to, and benefit less from psychotherapy than the general population (Kobel et al., 2020). In this study, participants all experienced moderate-to-severe depression, anxiety, and/or PTSD symptoms at admission, and they described being significantly impacted, in terms of distress and dysfunction, at a time when they were experiencing an intense demand on mental capacity in the early stages of adapting to a new environment and culture, learning a new language, building new relationships, and rebuilding livelihood. Consistent with previous studies, refugees who engaged in psychotherapy demonstrated a significant reduction of depressive and anxiety symptoms, but posttraumatic symptoms did not reduce as significantly. As the postevaluation screening indicated, approximately 20% of clients were still symptomatic for PTSD when they ended their counselling sessions. While of these, most reported experiencing benefits such as learning to understand symptoms and fear them less, others reported that it was too painful or overwhelming to recall and discuss traumatic material. Clinical challenges with pacing and emotional regulation are very common with trauma-focused treatment (Ogden et al., 2006; Siegel, 1999). This suggests that for a small proportion of severely traumatized clients more specialized, longer term psychological treatment is indicated.

Implications

This study has implications for therapists. Our findings suggest that therapists who register with IFHP to receive reimbursement for their work with refugee clients may be more effective if they partner with settlement agencies to provide settlement-integrated care. Qualitative findings also suggest that refugee clients are well served by counsellors who can offer culturally responsive services in first language, but trust building is essential to allay the fears that refugee survivors of political persecution may have of their compatriots.

This study also has implications for programme development. Settlement services that integrate a trauma-informed approach can facilitate timely detection and intervention through early screening and referral to mental health professionals. Mental health programmes that work in collaboration with settlement agencies and use a culturally responsive approach can promote trust, reduce stigma, and offer culturally relevant assessment and treatment plans.

Our findings also have policy implications. Under international law, Canada has humanitarian obligations to recognize the right to health by assuring good quality health care for all, including refugees (Library of Parliament, 2015). The IFHP and mainstream public mental health services do not currently provide accessible, culturally responsive, trauma-informed, and effective mental health treatment to address the psychological needs of refugees. The findings of this study suggest that a settlement-integrated approach could augment publicly funded services and would better serve this vulnerable, underserved population.

Conclusions

The results of this study suggest, overall, that the interventions had an important role in the reduction of refugee clients' symptoms of anxiety, depression, and PTSD, and that participants were highly satisfied with the experience and outcomes of counselling. Our findings suggest that mental health services that are integrated into a settlement agency, in which mental health clinicians had knowledge of the broad range of refugee mental health issues and the flexibility to focus on those deemed most currently distressing, was effective for most participants. For those refugee participants with more severe and/or chronic PTSD symptoms, more specialized therapy was indicated.

Further research is needed to determine assessment and treatment strategies to support the development of an effective stepped-care model, in which more intensive resources can be allocated to those with more complex and severe needs along the spectrum from settlement support, community-based mental health promotion and prevention, generalist counselling, specialist psychotherapy, to primary care and psychiatric treatment. In addition, as our study participants demonstrated, there are experiences and aspects of identity that make refugees particularly vulnerable—for example, survivors of torture and sexualized violence; people with disabilities; and those who are elderly, trans, illiterate, single parents of preschool-aged children, or from countries without established communities in the host country. Programme development efforts must address a wide range of diverse mental health needs and barriers that exist for vulnerable groups within the refugee population.

There are threats to internal validity associated with naturalistic studies, and the study of evidence-based mental health interventions for refugees is complicated by the hyperdiversity of the participants, as well as by the need to balance treatment of past traumatic experiences with attention to the processes of adaptation and acculturation. However, this naturalistic observational study has strong ecological validity and, when considered alongside the growing body of efficacy research for mental health interventions, can help inform clinical practice, service delivery, and policy decisions. This knowledge will contribute to the development of a socially and culturally responsive practice of psychology in Canada.

Résumé

Cette étude de type naturaliste menée dans la communauté visait à examiner un modèle « intégré à l'établissement » de la santé mentale des réfugiés. Les soins de santé mentale étaient coordonnés par un organisme d'aide à l'établissement ainsi que par une équipe composée de travailleurs et de conseillers en établissement polyglottes et adaptés à la culture qui ont fourni des services d'aiguillage et de counseling afin de s'attaquer aux symptômes d'anxiété, de dépression et de stress post-traumatique, ainsi qu'aux problèmes d'adaptation socioculturelle. Un modèle de recherche à méthodes mixtes a été appliqué dans le but d'évaluer la réduction des symptômes de dépression (questionnaire de santé du patient pour évaluer la dépression en neuf questions), d'anxiété (trouble d'anxiété généralisé, sept questions), et de stress post-traumatique (questionnaire Harvard, évaluation de 16 symptômes), de déterminer la satisfaction des clients au moyen d'un questionnaire en sept questions, et de comprendre l'expérience de counseling des clients en menant des entrevues qualitatives semi-structurées. Durant l'intervention, les réfugiés participants ($N = 74$, taux de réponse de 86 %) au programme de santé mentale intégré à l'établissement ont présenté des réductions notables de leurs symptômes d'anxiété ($t[73] = 12{,}89$, $p <$,001, $d = 1{,}9$), de dépression ($t[73] = 10{,}77$, $p <$,001, $d = 1{,}3$) et de stress post-traumatique $t[73] = 10{,}77$, $p <$,001, $d = 1{,}3$). Les entrevues qualitatives menées auprès des réfugiés participants ont fourni un aperçu (a) du fardeau que représentent les problèmes de santé mentale non traités, (b) de leur perception de la maladie mentale et des traitements connexes, (c) de leur expérience relative aux services de santé mentale intégrés à l'établissement et du counseling dans leur langue maternelle, (d) de leurs observations de leurs progrès, et (e) de leur évaluation de leur propre expérience du counseling. Ces résultats de recherche à méthodes mixtes donnent à penser que les services en santé mentale spécialisés et adaptés à la culture offerts dans le cadre d'un établissement réduisent les barrières à l'accès à de tels services, car les intervenants sont réactifs aux besoins et aux préférences des réfugiés, si bien qu'ils permettent de réduire efficacement les symptômes d'anxiété, de dépression et de stress post-traumatique.

Mots-clés : santé mentale des réfugiés, recherche menée dans la communauté, méthodes mixtes

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